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THE HEALTH LAW PARTNERS

HOT LEGAL ISSUES WITH MA PLANS

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OVERVIEW

- **Office of Inspector General (OIG) report, September 2018**
- **Network adequacy**
  - *Fairfield Co. Medical Assn. v. United Healthcare of New England,* 985 F.Supp.2d 262 (D. CT 2013)
  - *Fairfield Co. Medical Assn. v. United Healthcare of New England,* 557 Fed.Appx. 53 (2nd Cir. 2014)
  - Issues involving Medicare Advantage plan directories
- **Recent case law**
  - *RenCare, Ltd. v. Humana Health Plan of Texas, Inc.,* 395 F.3d 555 (5th Cir. 2004)
  - *Liberty Dialysis-Hawaii LLC v. Kaiser Foundation Health Plan, Inc.,* 2017 WL 4322385 (D. Hawaii 2017)
  - *Prime Healthcare Servs., et al. v. Humana Ins. Co.,* 298 F.Supp.3d 1316 (C.D. California 2018)

OIG REPORT, SEPTEMBER 2018

- The OIG has expressed concerns that under the Medicare Part C payment methodology, there is a risk that insurers are incented to improperly deny access to services and payment in order to increase profits.
  - Under the Medicare Part C capitated payment model, beneficiaries enroll in a managed care plan and Medicare pays the insurer (called a Medicare Advantage Organization (MAO)) a risk-adjusted payment each month for as long as the beneficiary is enrolled.
  - In exchange for the monthly payment, the MAO agrees to authorize and pay for all medically necessary care for the beneficiary that falls within Medicare's benefits package.
  - *Contrast Parts A and B, where the financial risk is borne entirely by CMS. Funds are paid directly to providers for each qualifying service. However, under Part C, CMS pays the MAO a fixed monthly payment, regardless of the value of services actually provided.*

OIG REPORT, SEPTEMBER 2018

- Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials
  - https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf

- Purpose:
  - *A central concern about the capitated payment model used in Medicare Advantage is the potential incentive for MAOs to inappropriately deny access to services and payment in an attempt to increase their profits…*
  - *Because Medicare Advantage covers so many beneficiaries (more than 20 million in 2018), even low rates of inappropriately denied services or payment can create significant problems for many Medicare beneficiaries and their providers.*

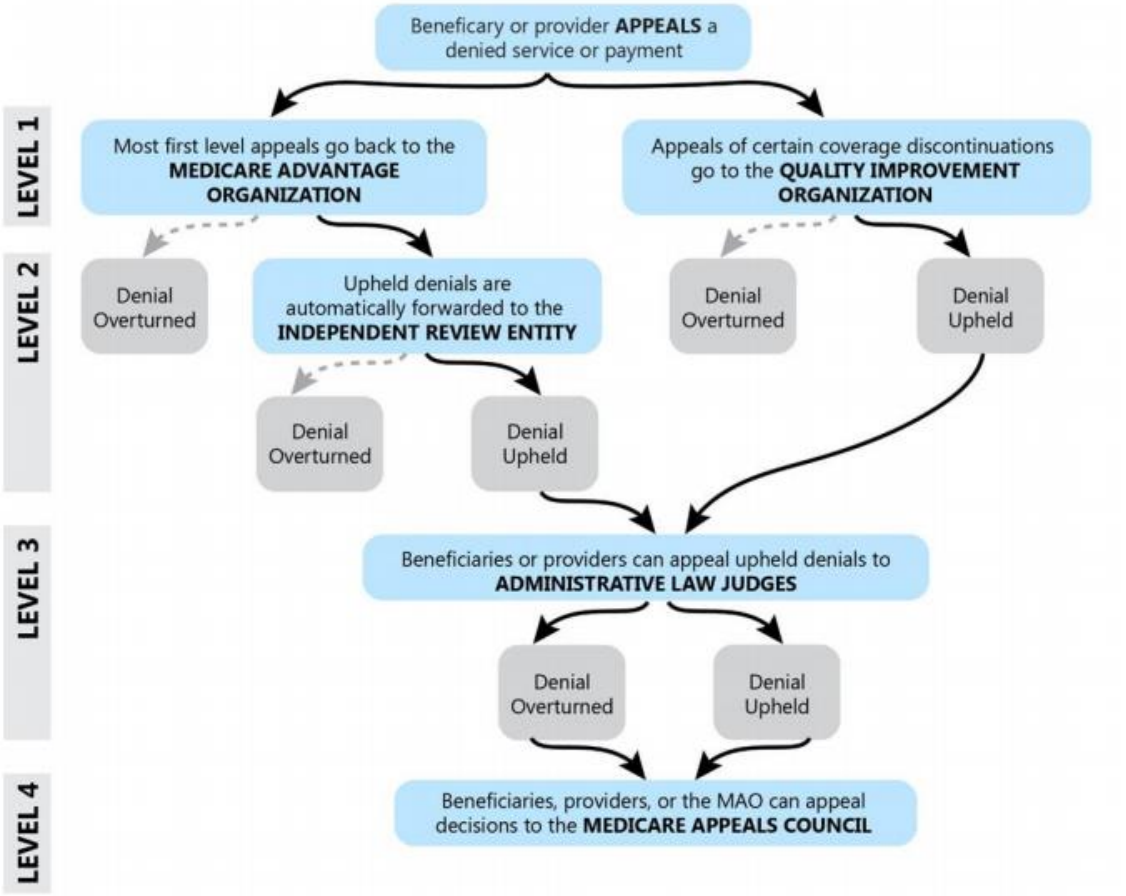
OIG REPORT, SEPTEMBER 2018

- Method:
  - The OIG collected data on denials, appeals, and appeal outcomes from 2014-2016 at each level of the Medicare Advantage appeals process.
    - OIG calculated the volume and rate of appeals and overturned denials at each level.
  - To examine CMS oversight, the OIG analyzed CMS's 2015 audit results and the resulting enforcement actions.

OIG REPORT, SEPTEMBER 2018

- *Medicare Part C Appeals Process:*

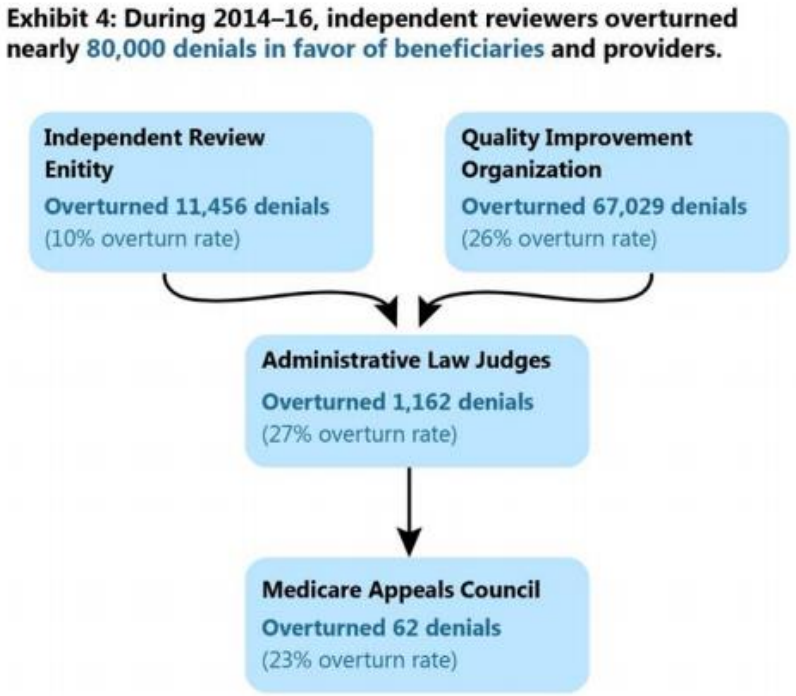
Exhibit 1: Beneficiaries and providers can appeal Medicare Advantage denials to multiple levels of review within the Department of Health and Human Services.



Source: OIG analysis of the Medicare Advantage appeals process, 2018

OIG REPORT, SEPTEMBER 2018

- Findings:
  - From 2014-2016, beneficiaries and providers appealed more than 863,000 denials to their MAOs
    - **Level (1):** MAOs overturned 75 percent of their own denials during 2014-2016 (~ 649,000 denials total, or ~216,000 denials/year)
    - **Level (2):** IROs overturned an additional 10 percent of MAO denials (constituting ~80,000 denials)



OIG REPORT, SEPTEMBER 2018

- Repercussions:
  - Each overturned denial represents a case in which beneficiaries or providers had to file an appeal to receive services or payment that are covered by Medicare.
    - This extra step creates friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs.
  - Although overturned payment denials do not affect access to services for the associated beneficiaries, the denials may impact future access.
    - Providers may be discouraged from ordering services that are frequently denied—even when medically necessary—to avoid the appeals process.

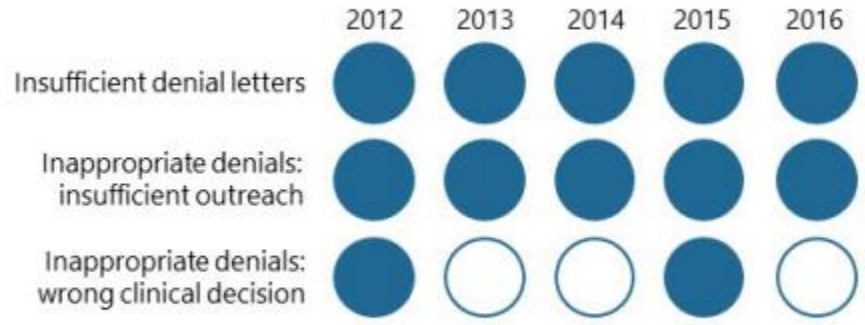
OIG REPORT, SEPTEMBER 2018

- *CMS Oversight:*
  - Program audits
    - Following a program audit, CMS requires MAOs to implement corrective action plans to address any audit violations found before the audit is closed.
  - Compliance and enforcement actions
    - Enforcement actions may include civil monetary penalties (CMPs); intermediate sanctions, such as suspension of marketing, enrollment or payment; or terminating a contract.

OIG REPORT, SEPTEMBER 2018

- *Program audit findings*:
  - (1) Medicare Advantage beneficiaries and providers rarely used the appeals process
    - During 2014-2016, beneficiaries and providers appealed 1.1 million out of the 101.1 million denials made by MAOs for a 1.1 percent appeals rate.
  - (2) Widespread and persistent problems related to denials of care and payment in Medicare Advantage

Exhibit 5: Violations related to denials were among the most common audit violations each year during 2012–16.



Note: solid circles indicate that the audit violation was among the five most common violations in that year.

Source: CMS's 2012-16 Part C and Part D program audit and enforcement reports, 2018.

OIG REPORT, SEPTEMBER 2018

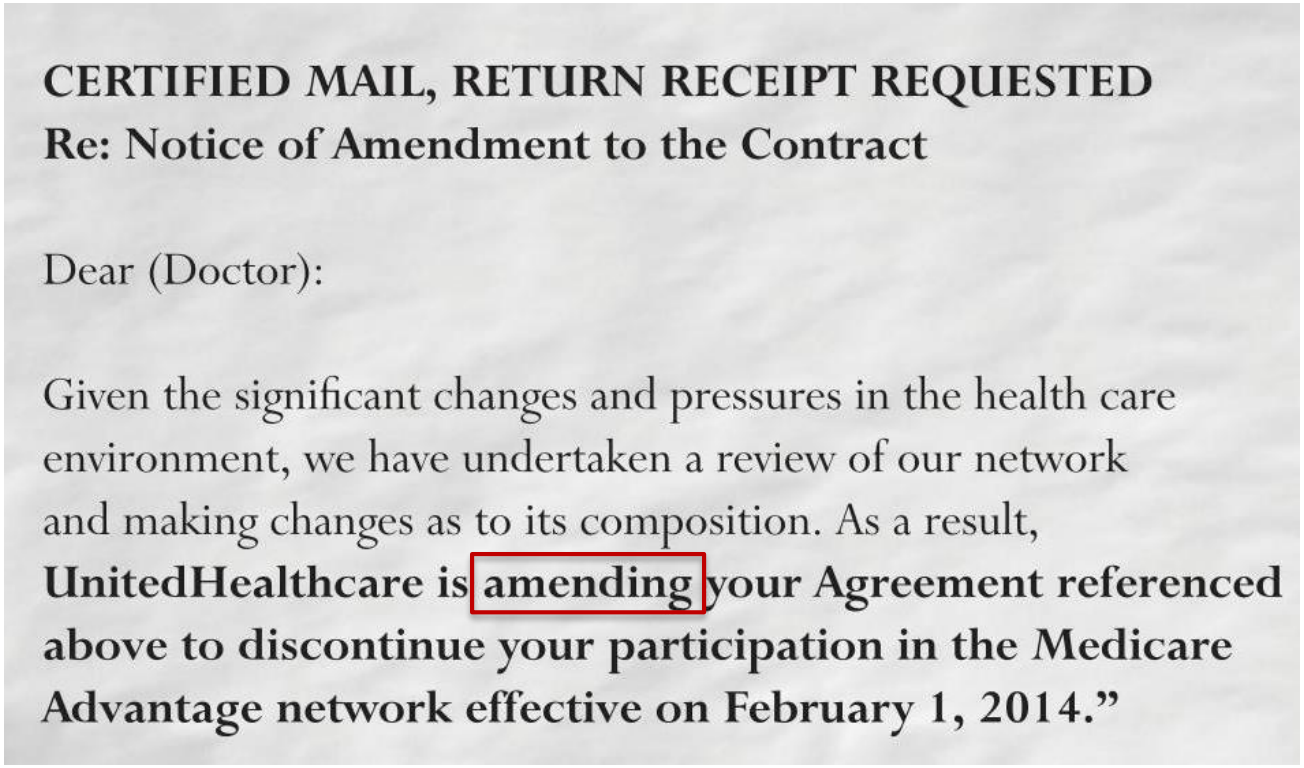
- Recommendations:
  - Enhance oversight of MAO contracts, including those with high overturn rates and/or low appeal rates and take corrective action as appropriate.
  - Address persistent problems related to inappropriate denials and insufficient denial letters in Medicare Advantage.
  - Provide beneficiaries with clear, easily accessible information about serious violations by MAOs.
  - *CMS concurred with each of these recommendations.*

NETWORK ADEQUACY

- CMS requires MAOs to maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served.

NETWORK ADEQUACY

- On October 2, 2013, Jenny Hayhurst, Vice President, Network Management, UnitedHealthcare sent a letter to thousands of physicians in at least 10 states, which stated the following:



CERTIFIED MAIL, RETURN RECEIPT REQUESTED
Re: Notice of Amendment to the Contract

Dear (Doctor):

Given the significant changes and pressures in the health care environment, we have undertaken a review of our network and making changes as to its composition. As a result, **UnitedHealthcare is amending your Agreement referenced above to discontinue your participation in the Medicare Advantage network effective on February 1, 2014."**

NETWORK ADEQUACY

- In response, the American Medical Association (AMA), together with 42 national specialty medical associations, and 39 state medical associations drafted a letter to the then-Administrator of the Centers for Medicare & Medicaid Services (CMS), Marilyn Tavenner, expressing their concerns with the "amendments"/terminations of so many physicians from UHC's Medicare Advantage Network.

NETWORK ADEQUACY

- The Fairfield County Medical Association and Hartford County Medical Association, Inc. filed an emergency motion for a temporary restraining order against UHC, seeking to:
  - (1) Enjoin UHC from terminating 2,200 physicians from UHC's Medicare Advantage Network;
  - (2) Enjoin UHC from notifying its Medicare Advantage customers that certain physician members would be terminated from the Medicare Advantage Network as of February 1, 2014; and
  - (3) Compel UHC to reinstate, advertise, and market the affected physicians in their 2014 directories for the Medicare Advantage Network

- The Plaintiffs' motion was successful (and upheld by the 2nd Circuit on appeal) to enjoin UHC from taking action against the physicians until 30 days following February 7, 2014, to grant the affected physicians the opportunity to challenge their terminations.
  - 557 Fed.Appx. 53 (2nd Cir. 2014)

NETWORK ADEQUACY

- Although *Fairfield Co. Medical Assn.* was decided in 2013, MAOs continue to terminate providers' agreements to participate in networks for specious reasons.

NETWORK ADEQUACY

- Pursuant to 42 C.F.R. § 422.202 (d):
  - *Suspension or termination of contract.* An MA organization… must meet the following requirements:
    - *(1) Notice to physician.* An MA organization that suspends or terminates an agreement under which the physician provides services to MA plan enrollees must give the affected individual written notice of the following:
      - (1) The reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by the MA organization.
      - (2) The affected physician's right to appeal the action and the process and timing for requesting a hearing.

NETWORK ADEQUACY

- 42 C.F.R. § 422.112 addresses "**Access to services**"
  - Maintain and monitor a **network of appropriate providers**… and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics and other providers…
  - ***Specialty care***. Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist… The [MAO] arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs…
  - ***Hours of operation***. Ensure that – (i) The hours of operation of its MA plan providers are convenient to the population served under the plan and do not discriminate against Medicare enrollees; and (ii) Plan services are available 24 hours a day, 7 days a week when medically necessary.
  - ***Cultural considerations***. Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.
  - ***Prevailing standards of community health care delivery***.

- *See also* https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf

NETWORK ADEQUACY

- Network adequacy considerations on appeal of a physician's termination from a MA Network:
  - Strategies on appeal:
    - Is the physician a specialist? Are there other specialists in the network that would be adequate (given distance, whether or not they accept new patients, etc.) to meet patients' needs?
    - What are the hours of operation for the terminated physician and other physicians in the network?
      - Do the work to obtain accurate information
    - Are there relevant cultural considerations?
      - LEP, multiple languages
    - Location issues/public transportation/real offices etc.

NETWORK ADEQUACY

- **Online provider directory review report**
  - CMS completed its 3rd round of MA online provider directory reviews between November 2017 and July 2018.
  - The review examined the accuracy of 108 providers and their listed locations selected from the online directories of 52 MAOs (which is approximately 1/3 of all MAOs), for a total of 5,602 providers at 10,504 locations
  - Findings:
    - 48.74% of the provider directory locations listed had at least one inaccuracy, including:
      - The provider was not at the location listed,
      - The phone number was incorrect, or
      - The provider was not accepting new patients when the directory indicated they were.
  - Concerns:
    - Access to care barriers

https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf

RECENT CASE LAW

- *RenCare, Ltd. v. Humana Health Plan of Texas, Inc.*, 395 F.3d 555 (5th Cir. 2004)
- *Liberty Dialysis-Hawaii LLC v. Kaiser Foundation Health Plan, Inc.*, 2017 WL 4322385 (D. Hawaii 2017)
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CONTRACT VS NON-CONTRACT PROVIDERS

- ***Contract providers*** have contractual relationships with the MAO, and the MAO pays contractually agreed upon rates.
  - *There are very few restrictions placed on such contracts*
- ***Non-contract providers*** must receive the same rates set by the Medicare Act for the services it provides.

EXHAUSTION OF ADMINISTRATIVE REMEDIES

- Section 405(h) of the Social Security Act specifies that judicial review of claims *arising under* the Medicare Act is available only after the Secretary renders a "final decision" on the claim.
- The Supreme Court has interpreted the phrase *arising under* broadly.
  - A claim arises under the Medicare Act when "both the standing and the substantive basis for the presentation" of the claim is the Medicare Act, or when a claim is "inextricably intertwined" with a claim for Medicare benefits.
    - *Heckler v. Ringer,* 466 U.S. 602 at 614-15, 624 (1984)

RECENT CASE LAW

- *RenCare, Ltd. v. Humana Health Plan of Texas, Inc.*, 395 F.3d 555 (5th Cir. 2004)
  - Humana, a MAO, contracted with RenCare (a "contract provider") to provide kidney dialysis services to its enrollees.
  - A dispute arose over Humana's reimbursement to RenCare for the services it provided, and RenCare sued Humana in TX state court for: breach of contract, detrimental reliance, and fraud (among other state law causes of action).
  - The case was removed to federal court. The 5th Circuit found that the substantive basis for RenCare's claims were state law and thus were "clearly not the Medicare Act," and RenCare's claims were not intertwined with a claim for Medicare benefits.
  - Therefore, RenCare was permitted to proceed with its case.

RECENT CASE LAW

- *Liberty Dialysis-Hawaii LLC v. Kaiser Foundation Health Plan, Inc.,* 2017 WL 4322385 (D. Hawaii 2017).
  - Kaiser Foundation Health Plan, Inc. (KFHP), a MAO, moved to dismiss a complaint filed by Liberty. KFHP argued that the court lacked subject matter jurisdiction (SMJ) because Liberty's claims arose from the Medicare Act, and Liberty had not presented its claims to the Secretary of Health and Human Services nor exhausted administrative remedies. The court found that the claims did not arise under the Medicare Act and denied KFHP's motion to dismiss.

RECENT CASE LAW

- *Liberty Dialysis-Hawaii LLC v. Kaiser Foundation Health Plan, Inc.,* 2017 WL 4322385 (D. Hawaii 2017).
  - Liberty provided outpatient renal dialysis to KFHP members subject to the terms of a letter agreement (and thus, was a "contract provider").
  - Kaiser Foundation Health Plan, Inc. (KFHP), a MAO, moved to dismiss a complaint filed by Liberty (in which Liberty alleged breach of contract, in that KFHP had ceased making payments in accordance with the letter agreement).
  - KFHP moved to dismiss Liberty's complaint, arguing that Liberty's claims arose from the Medicare Act, and Liberty had not presented its claims to the Secretary of Health and Human Services nor exhausted administrative remedies.
  - The court found that because Liberty was a contract provider (and the government's risk was therefore extinguished), the dispute was solely between the entities and was not intertwined with Medicare benefits.

RECENT CASE LAW

- *Prime Healthcare Servs., et al. v. Humana Ins. Co.*, 2018 WL 8131763 (C.D. California 2018)
  - Prime entered into a series of Letters of Agreement, under which Prime agreed to provide hospital services to Humana's MAO enrollees ("*contract provider*").
  - Prime alleged that Humana underpaid for services it provided by down-coding claims it had submitted.
  - Prime brought action against Humana, alleging breach of written contract.
  - Humana moved to dismiss on the grounds that the Medicare Act preempted all of Prime's claims.

RECENT CASE LAW

- *Prime Healthcare Servs., et al. v. Humana Ins. Co.*, 2018 WL 8131763 (C.D. California 2018)
  - When addressing a question of preemption:
    - Identify a specific CMS regulation or standard that governs the plaintiff's claim; and
    - If such regulation or standard exists, determine whether the regulation or standard conflicts with the state or common law at issue.
  - In concluding that Prime's lawsuit could proceed (and its breach of contract claim was not preempted:
    - The court noted that the only regulation identified by Humana that directly related to the contract between MAOs and contract providers was 42 C.F.R. § 422.520(b), which requires contracts between MAOs and providers to contain a prompt payment provision.
    - The court found that Prime's breach of contract claim did not undermine or compete with the regulation.

QUESTIONS?

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